INTRODUCTION

The Federal Interagency Committee on Emergency Medical Services (FICEMS) met on Thursday, June 24, 2010 from 9:00 a.m. to 12:00 p.m. in the Truman Room of the White House Conference Center, 726 Jackson Pl., Washington, DC.

MEMBERS IN ATTENDANCE

Department of Transportation (DOT)

David Strickland, Chair
Administrator, National Highway Traffic Safety Administration

Department of Homeland Security (DHS)

Glenn Gaines
Acting U.S. Fire Administrator
U.S. Fire Administration (USFA)

Alexander Garza, MD
Assistant Secretary of Health Affairs/Chief Medical Officer
Office of Health Affairs (OHA)

Department of Health & Human Services (HHS)

Kevin Yeskey, MD, FACEP, Immediate-Past Chair of FICEMS
Deputy Assistant Secretary
Office of the Assistant Secretary for Preparedness and Response (ASPR)

Rick Hunt, MD
Director, Division of Injury Response
Centers for Disease Control and Prevention (CDC)

Jean Sheil
Senior Advisor, Office of Operations Management
Center for Medicare and Medicaid Services (CMS)

David Heppel, MD
Director, Division of Child, Adolescent and Family Health
Health Resources and Services Administration

David Boyd, MDCM, FACS
National Trauma Systems Coordinator
Indian Health Service (IHS)

Department of Defense
Colonel Nancy Dezell
Director of Program Integration
Office of the Assistant Secretary of Defense (Health Affairs)

Federal Communications Commission (FCC)
No Representation

State EMS Director
Robert Bass, MD
Executive Director, Maryland Institute for Emergency Medical Services Systems

BACKGROUND

The Federal Interagency Committee on Emergency Medical Services (FICEMS) was established by the Safe, Accountable, Flexible, Efficient Transportation Equity Act: A Legacy for Users (42 U.S.C. § 300d-4). FICEMS is charged with coordinating Federal Emergency Medical Services (EMS) efforts for the purposes of identifying state and local EMS needs, recommending new or expanded programs for improving EMS at all levels, and streamlining the process through which Federal agencies support EMS and 9-1-1.

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FICEMS Assessment Committee Proposed 2 Year Priorities 2009-2011
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National Transportation Safety Board (NTSB) Safety Recommendation Letter – March 17, 2010
FICEMS Response to NTSB Recommendation H-09-4
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FICEMS Response to NTSB Recommendations A-09-102 & A-09-103
Executive Summary FICEMS National EMS Stakeholder Meeting, March 17-18, 2010
NHTSA Request for Proposals (RFP) Announcement for Developing and Promoting a National "Culture of Safety" Strategy in EMS; Culture of Safety Statement of Work
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FICEMS Membership List

MEETING MINUTES

OPENING REMARKS

The eighth FICEMS Meeting was called to order by David Strickland, Administrator, National Highway Traffic Safety Administration (NHTSA). Mr. Strickland introduced himself as the

newly elected Chair of FICEMS, talked about his background and being with FICEMS since its inception. Strickland praised the progress that FICEMS has made and that it has moved the ball forward for first responders and emergency medical services across the country. He invited the FICEMS committee members, their staffs, and audience participants to introduce themselves. He expressed that it was his pleasure to serve as chair.

Following introductions of the committee and audience, Mr. Strickland acknowledged Ed Dolan of the National Security Staff and thanked him for securing the White House Conference Center's Truman Room for the FICEMS meeting.

REVIEW OF MINUTES, DAVID STRICKLAND
Mr. Strickland opened for any discussion of the minutes and Drew Dawson noted there were some editorial comments and proposed a couple of technical amendments. Strickland moved for approval of the January meeting minutes and they were approved unanimously.

TECHNICAL WORKING GROUP (TWG) COMMITTEE REPORTS AND WORK PLAN UPDATES, DREW DAWSON
Drew Dawson summarized the Technical Working Group's purpose and activity at last meeting:

- At the last meeting work plans were adopted for each committee
- TWG serves as the FICEMS staff and takes direction and guidance from FICEMS. Each committee meets by conference call once a month and TWG meets by conference call once per month
- Each committee has made progress on their work plans
- Asked for comments and suggestions on current level of progress
- Sought input on any priorities for the TWG in addition to work plans
- Sought to coordinate efforts among Federal agencies

Mr. Dawson referred members to the modified "2-Year Work Plans" documents provided in the meeting binder and announced that each subcommittee chair would give a status report.

ASSESSMENT COMMITTEE, Rick Patrick
Mr. Patrick referred attendees to the Assessment Committee Proposed 2 Year Priorities in the binder for more complete information. He directed the meeting's attention to two important points, the first regarding communications and interoperability, described as a major issue in operations "for all emergency services. The Assessment Committee will be determining how it can help with interoperability issues. Under the auspices of NHTSA Office of EMS through a relationship with the National Association of State EMS Officials, there's already active participation with the Federal Communications Commission to address communications and interoperability issues and Mr. Patrick said he presumes that the FICEMS TWG/Assessment Committee can build upon all of that work. Second item he discussed dealt with cost effectiveness which the committee has not engaged with that yet to any significant degree. There is tentatively a meeting scheduled in July to start looking at both of these items. Mr. Patrick asked Cathy Gotschall for amplifying feedback or comments. She recognized Dr. Mears and his work with the National EMS Assessment, and said they looked forward to his presentation later during the meeting.

MEDICAL OVERSIGHT COMMITTEE, DR. Richard Hunt

Rick Hunt, CDC's Injury Center, Division of Injury Response, is chair of the Medical Oversight Committee of the Technical Work Group. The work group from its history had early success with a letter from FICEMS' chair requesting agencies and departments to assure that medical oversight was included in any EMS-related federal grants. Subsequently, because of real interest in forwarding the cause of evidence-based practice in EMS, the group worked collaboratively with FICEMS, other work groups and internal experts on the evidence-based practice guideline model that Cathy Gotschall would address later in the meeting. Because there were personnel changes as a result of the 2008 election, Hunt and Dawson discussed the committee membership makeup and are thinking about suggested people who may need to be at the table to provide new insight.

DATA AND RESEARCH COMMITTEE, Daniel Kavanaugh

Mr. Kavanaugh explained that the committee's first area of focus is educating Institutional Review Boards (IRBs) on exceptions from informed consent policies and procedures. One near term goal was to disseminate the document that was developed out of the National EMS Research Agenda Conference held two years ago about using exceptions from informed consent for emergency research. That document is still going through the clearance process at NHTSA. But once it is posted by EMS.gov, the goal is to formalize a dissemination plan and to develop a resource kit for IRB's based this document. The committee's longer term goal related to this objective is to evaluate the feasibility of key elements on centralization of IRB review for emergency care research. The Council on Emergency Medical Care within HHS/ASPR has been working on topics related to facilitating emergency care research and will be contemplating a potential RFI as it relates to this. This committee would be collaborating in that effort and providing input as will the FDA and the Office of Human Research Protection.

In terms of the second objective on expanding the utilization of NEMSIS data, version 3.0 was sent out February 2010 and version 3.0 will be sent out this month. Federal partners have been involved in giving input since its release. One goal of the committee was to gain federal support for linking the NEMSIS database to HL7 health care database sets. Dr. Mears was very involved in the effort down in Brazil where comments were received from the initial NEMSIS domain analysis model within HL7, meaning it's about a third of the way there to link the NEMSIS data set in the health IT community. This was the first step. Federal partners include NHTSA and CDC going forward.

On the issue of utilizing data to improve safety in EMS, the Culture of Safety RFP has been released from NHTSA. EMSC is holding a competition for targeted issues which included this as an area applicants could respond to; applications will be reviewed this summer. For successful applications, they anticipate award notifications by August 1. The award would be $300,000 a year for three years. This was specifically formulated as a means of addressing this objective. Last year, NIH Medical Surgical Emergency Research Roundtables were held and manuscripts were submitted to the Annals of Emergency Medicine which are to be published soon. The objective of these discussions was to identify key research questions for emergency care, discuss where barriers exist and explore ways to advance emergency care research. The committee will be looking at suggestions for greater federal support in that area when the manuscript is published.

PREPAREDNESS COMMITTEE, Dr. Robert Bass
This committee is focused on three focus areas: Pandemic influenza preparedness; Mass Casualty Incident (MCI) triage; and MCI preparedness. On pandemic influenza, the committee is monitoring implementation of action steps on the FICEMS report, "State EMS System Pandemic Influenza Preparedness: a Report of the FICEMS", approved by FICEMS in November 2009 and released to the public in December 2009. As requested by FICEMS, they are specifically looking at action step 1.3 which is the recommendation to create a new State EMS system pandemic influenza preparedness grant program to address issues outside the scope of existing grant programs in an effort to close identified gaps. A working group is developing recommendations to FICEMS regarding how such a program would be administered, as well as project and budget considerations. Dr. Bass then asked for a non-public executive session meeting on this issue before the next FICEMS meeting.

A motion is put forth for an executive session of FICEMS to discuss this grant program and is passed unanimously.

With regard to MCI triage, the committee has been working closely with the CDC's Terrorism Injuries Information Dissemination Exchange (TIIDE). TIIDE is developing model uniform core criteria (MUCC) for MCI triage. The MUCC has already been endorsed by a number of national organizations including the American College of Surgeons. The committee is following this work closely and will have some recommendations regarding the MUCC for FICEMS. In terms of MCI preparedness, the committee is hoping for data and information to come out of the NHTSA national EMS assessment and it will look at that data to identify gaps and make recommendations to help close those gaps.

Question: Is there a timeline for the various agencies to provide data on preparedness?

Bass: There are timelines. The current assessment is about a year and a half and we're two or three months into that. The hope is that the committee will have some information early next year that can be distilled into a final report. The assessment will be looking at EMS in its entirety and the committee has met with them to identify issues associated with preparedness

Mr. Strickland asked in terms of federal responsibilities how states are looking at data and whether they would be working with some of these federal agencies. Dr. Bass responded that for now the work is internal but when the committee gets new information it will share it with the states and partner with them. The committee also had some dialogue with the National EMS Advisory Council.

SAFETY COMMITTEE, Rick Patrick
The committee has begun to address three core areas. First, the committee is looking at the National EMS Advisory Council (NEMSAC) EMS Patient Safety information produced over the last two years The FICEMS Safety committee came up with a similar proposal which mirrors what we are hearing from our constituents in the field across the nation. Now it's a matter of prioritizing and resourcing both personnel and financial resources to support these issues. An example that shows the benefit of this collaboration dealing with EMS and ambulance safety:

Some EMS colleagues in the field approached DHS Science & Technology—Jim Grove's group—to come up with ambulance design standards, not knowing that GSA already has them. A number of federal partners, Drew Dawson, Rick Patrick, Bill Troop, Jim Green and John McDonald from the GSA sit on the National Fire Protection Association's committee for ambulance design. This is important because GSA is getting out of the design standards business and has turned everything over to the Nat'l Fire Protection Association. NFPA 1917 (in the promulgation stage and due out July 1 for public comment) has taken everything from the GSA Triple K standard and incorporated it into the existing standard concepts that NFPA follows with a lot of expertise from virtually all national organizations as well as the Federal government. But the utility of FICEMS on this particular subject, is that when Jim brought this to my attention we were able to engage Drew Dawson from NHTSA, NIST and the National Institutes of Occupational Safety and Health (NIOSH) through the CDC and Jim Green there who were already doing some extensive stuff on EMS and ambulance safety, we brought everybody to the table. Now we're moving forward on the federal side of the house and with NFPA. That collaboration has seemed to save a lot of time and effort and tax payer dollars.

He emphasized that working with colleagues has been phenomenally helpful but the Safety Committee is perhaps ill represented from every FICEMS member agencies. We have representatives from USFA, DHS, Office of Health Affairs, NHTSA and NIOSH although NIOSH isn't an official FICEMS representative.. We are trying to increase that representation on the committee as we move forward.

There is a position statement that the committee is asking FICEMS leadership to look at it for input, suggestions, comments, edification or acceptance and endorsement with the hope that the position statement can be published on EMS.gov Mr. Strickland I turn it back over to you for comments or discussion on the position statement itself or other issues.

Glenn Gaines stated that his agency has produced a video about hazards to fire fighters, EMTs and other first responders while on the scene of and/or returning from incidents. Each year the second leading cause of line-of-duty-deaths involves transportation. Mr. Gaines promised members a copy of the video.

EDUCATION AND WORKFORCE COMMITTEE, Mike Stern
The Education and Workforce Committee was recently formed and met for the first time about a month ago. The group has created a draft work plan that is still being reviewed, and should be ready to share at the next Technical Working Group meeting and on up the chain. The group is looking at three focus areas: 1) Federal EMS education and training what the Federal entities are disseminating, providing or creating; 2) The EMS Education Agenda for the Future which is an ongoing issue we need to help implement; and 3) the EMS workforce agenda for the future, again to review implementation, etc.

9-1-1/MEDICAL COMMUNICATIONS AD HOC COMMITTEE, Laurie Flaherty
This is an ad hoc committee and the primary area they've been involved with has been on NTSB recommendations and they will defer their comments until that subject comes up for discussion.

HEALTH CARE REFORM ACT, Andrew Roszak

Andrew Roszak, with the Emergency Care Coordination Center at HHS/ASPR introduced himself. The committee was formed in May when it was determined there was a need at TWG level to examine the ways that health care reform can affect EMS. The group began by examining the law and looking at different provisions to see how they related to EMS. The committee identified four sections that are ripe for immediate action.

- Section 3504 regionalized emergency medical care systems, transferred three trauma-related grant programs to ASPR from HRSA. This section also created a new grant program for the design and implementation of regionalized emergency medical care systems. The section is authorized for $24 million for each fiscal year 2010 through 2014. However, funds have not been appropriated.
- Section 5101, established the National Health Workforce Commission, a 15-person body appointed by the Comptroller General to advise Congress on all workforce issues including recruitment, retention, shortages and anticipated needs. And one area in the health care reform law that the commission is supposed to review as a high priority area is EMS. We think it's important to identify that and help the GAO and the Comptroller General as best we can.

Mr. Strickland asked whether the commission has a breakdown for participation or is it basically up to the Comptroller General to appoint the commission. Mr. Roszak responded that the law does specify who may be appointed to the commission but he doesn't think the commission has been established yet. Mr. Strickland noted that it's important for FICEMS to interface quickly to make certain it has not only input but perhaps representation on the commission, adding that it's always better to be inside the room than out. Mr. Roszak elaborated that the law says this commission can lean on any federal agency for support and this is an excellent place where FICEMS can interface. The text of the law says that the makeup of the commission will include representatives from the health care workforce, health care professionals, employers, third party payers, as well as individuals skilled in the conduct and interpretation of health care services and health care economics research, consumers, labor unions, state or local workforce investment boards and educational institutions.

- Section 3021 establishes the Centers for Medicare and Medicaid Services Innovation Center (CMI). The purpose of the CMI is to test innovative payment and service delivery models to reduce program expenditures. This is a ripe opportunity where EMS can get involved and provide some expertise if Medicare would like to look at different issues affecting EMS treat and release (inaudible).
- Sections 3013 & 3014 which are quality measurement development sections. These sections call for further development of quality measures that can be used as standards for performance and improvement of population health and health plans and provides for the delivery of health care in general.

Mr. Roszak then noted that the committee has four recommendations: 1) that FICEMS craft a letter to appropriate agencies in charge of implementation offering our expertise and integrating EMS into health care reform where it's appropriate; 2) that we conduct an internal FICEMS assessment of capabilities and resources available to assist Federal agencies in implementation; 3) That the committee actively monitor opportunities for integration of EMS into health care

reform implementation efforts; and 4) that the committee serve as a resource to FICEMS and the working group members.

On the committee are Gam Wijetunge, Dr. Bass, Dr. Boyd, Gina Piazza, Anthony Oliver, Fran Jensen, George Gentile and Noah Smith.

Mr. Strickland called for any discussion on the four recommendations made by the committee then moved to accept the recommendations as proposed and called for a vote. The recommendations were approved.

NATIONAL TRANSPORTATION SAFETY BOARD RECOMMENDATIONS AND PROPOSED STRATEGIES

MEXICAN HAT, UTAH RECOMMENDATIONS Dr. Bass

Dr. Bass began by noting that at the January 2010 meeting the FICEMS had received an update on the response to two NTSB recommendations regarding the incident that occurred in January 2008 involving a motor coach rollover near Mexican Hat, Utah. The first recommendation related to the need to ensure that there is access to emergency services. This was an area where there was no cell service and there are many miles of rural roads. There was substantial large bus traffic but no way to access the 9-1-1 system. NTSB suggested that we develop a plan to address this issue and we've brought on board Booz Allen Hamilton to help us develop this plan and you'll hear from the 9-1-1/medical communications ad hoc committee sometime in December with that plan.

Secondly, the recommendation from NTSB regarding response to this incident concerned states having adequate plans and processes in place to respond to these large scale incidents in rural areas. The Institute of Medicine has been contracted to do a workshop here in DC with experts on August 3 and 4 to discuss the challenges of responding to MCIs in rural areas and at the same time to step back and look at some of the innovative approaches in systems that have addressed this issue. The other piece of this is that we're working with the National Association of State EMS Officials, specifically their HITS committee, which is the Highway Incidents and Transportation System committee. They're looking at these issues and had a meeting back in April to kick off their process. They will be attending the August workshop and then meeting for two days afterwards so this is an opportunity for input in this area. The HITS committee will receive this input and continue their deliberations. The HITS committee is chaired by Dia Gainor, the State EMS Director of Idaho who is also chair of the National EMS Advisory Council. We're anticipating proceedings from the workshop sometime this winter and then we'll be hearing from the HITS committee with their guidelines in June of next year.

Dr. Bass motioned that the FICEMS TWG craft a letter to NTSB Chairman Deborah Hersman and give her an update about where we are and what our plans are in response to the NTSB's recommendations.

Laurie Flaherty had input here. The first recommendation from NTSB was related to emergency communications at the scene of the bus crash and we've been asked to put together a plan for local and state agencies to address challenges around communications in remote areas. We set a deadline to present the plan to FICEMS in December We've been collecting information from

subject matter experts nationally and in Utah and we're going to go back to vet that report and its feasibility so it's ready to present to FICEMS.

Mr. Strickland called for a vote on the motion to draft the letter to the NTSB chair and it passed unanimously.

Mr. Strickland added that this is a significant issue and noted that the board is concerned about the provision of services in remote areas. He stated that NHTSA is very concerned about this as are agencies across the government. Mr. Strickland emphasized that FICEMS needs to be very thoughtful and careful about this issue as Congress is very interested in this issue, especially the House Energy and Commerce Committee. As the next re-authorization period comes into view it is important to be thinking about the next generation of emergency communications.

Dr. Bass observed that the issues associated with Mexican Hat are the same issues that are raised when any mass casualty incident occurs. In a rural area it do not need to be 1,000 people to constitute an MCI. So it raises challenges with regard to response and therefore it was proposed that we break up the work shop to look at not just pre-hospital care but in-hospital as well. Mr. Strickland noted that there is always tension between the urban and rural spheres in terms of provisions of services but progress has been made and this is fantastic work.

HELICOPTER EMS RECOMMENDATIONS, Dr. Hunt and Cathy Gotschall
Dr. Hunt set the stage with a broad overview of the issue. The NTSB approached FICEMS within the last year to request assistance with significant concerns around air medical helicopter crashes. Toward that end at the last FICEMS meeting we approved an approach to their request. Those approaches are twofold: 1) to develop national guidelines for use of helicopter emergency medical transport by regional, local and state authorities during emergency medical response system planning; and 2) the development of national guidelines for the selection of appropriate emergency transportation modes for urgent care.

We've worked collaboratively and positively with NTSHA to use the evidence-based guidelines process that FICEMS developed to work towards evidence-based guidelines under a competitive contract with the Children's National Medical Center. And then following that, the second piece would be to work on those guidelines for the use and availability for helicopter emergency medical transport. Air medical transport is complex and it was important to start off with traumatic injuries as a beginning. Credit goes to FICEMS for the work towards an evidence-based guideline development process which provides a good foundation for mode of emergency transport decision-making.

That can feed into work we're doing through an interagency agreement we're doing between CDC and NHTSA on the use and availability of helicopter guidelines. At the last meeting we talked about the need for FICEMS to have periodic reports to the NTSB. The committee has been extraordinarily responsive to that request. Cathy Gotschall observed that Dr. Hunt summarized it well and noted that the group would be talking later about evidence-based guidelines.

Mr. Strickland asked about the reason that NTSB held a hearing on HEMS. Is this the overarching issue of triage decision-making regarding when helicopters are provided? Dr. Hunt

stated his perception is that NTSB has entered this space because of the increasing number of helicopter crashes.

Dr. Bass reiterated that what got their attention was the number of crashes. This is going to be a challenging process. Maryland is engaged with this and there's a paucity of literature out there and some issues aren't so much medical as operations based. We know that patients treated at a level one trauma center have a 25 percent decreased chance of mortality. However, in the field it is difficult to know who has major trauma and who doesn't. Therefore, we can use these mechanisms to determine who goes to the trauma center. The result may be a patient being over-triaged. At the same time however, if you don't get them to the trauma center where they can be evaluated those patients are more likely to die according to previous preventable death studies.

There are additional times when using helicopters clearly helps to support local EMS operations. If you are in a rural area with one EMS unit that covers a lot of territory, are you going to ask that one ambulance to transport one patient an hour or hour and a half up the road one way and come back thus depriving that area of a critical resource. How do you find evidence to support that process?

Mr. Strickland observed that it's interesting that NTSB's efforts to reduce the risk of these crashes have an impact on the provision of care from an operational standpoint. In some ways it is a bit of a conflict in terms of our mission to figure out the provision of these operational services and making sure that communities still have ambulances on the ground ready to serve the rest of the community while at the same time ensuring proper helicopter usage and flight and airspace control. Mr. Strickland pledged to have a follow-up conversation with Chairman Hersman while acknowledging that FICEMS efforts to put together triage protocols for the usage and provision of services versus flight risk and crashes will be a difficult but worthwhile undertaking.

There are no national guidelines on this issue. There is a critical interface here between the operational and medical piece although safety always needs to override any other consideration.

Mr. Strickland called for any further discussion. It is proposed that there be a similar motion to send a letter to the NTSB Chairman updating her on this discussion. Motion carried unanimously.

Dr. Boyd took the opportunity to note that there are about 85 ambulances that are tribally run and the Federal government supports that with an ambulance replacement program through GSA. There are about 160 vehicles out there and they replace about 20 per year. All these rural issues are difficult, sometimes we're dealing with communities where it's hard to provide any kind of a service and that's compounded by the isolation. One historical point that would be of interest is that the Department of Transportation actually funded the first trauma system in Illinois.

Mr. Strickland noted that Secretary of Transportation Ray LaHood has appointed a National EMS Advisory Council. A full report will be given when those names are announced.

NATIONAL EMS ASSESSMENT PROJECT UPDATE, Dr. Greg Mears

The National EMS Assessment Project was created to describe the commonalities of emergency medical systems. The goal of the project is to describe EMS systems using existing data sources.

Everyone around this table is familiar with the old adage that once you've seen an EMS system you've seen an EMS system. However, at the state or national level if one tried to describe an EMS system there's a huge amount of variety and diversity.

Another challenge is that we had identified over 50 organizations that had dissimilar data sources (e.g., live data, monographs, consensus statements, opinion documents, annual reports.. We also had gone through a process of using all of our EMS agenda documents for the future, had lots of preparedness information and actually created an outline that we felt included all the content that should be in an EMS assessment.

That got circulated back to the work groups and FICEMS and was expanded and adjusted and has been locked down here for a few months. So we're going back through all these documents from these sources to access the data that exists in these entities so we can start filling in this assessment description. There are a lot of people working on this. The University of North Carolina EMS Performance Improvement Center is the leader on the project, but included are the NEMSIS Technical Assistance Center at the University of Utah; the Critical Injury and Trauma Foundation with Nels Sanddal from a rural and wilderness perspective; and the National Association of State EMS Officials. This gives us a strong team that can touch each state and help us better identify where this information exists.

Based on data currently available, we learned that there is a need to grade or score the information for its usefulness. Physicians typically followed national recommendations or guidelines and ranked the data the recommendations are made from, where the highest ranked data would be that you can crunch and it's complete and the lowest being "people think this is the right thing to do" but there's nothing to prove that.

What we're finding is that we need to rank this information in a similar fashion. So we're grouping this information as we pull it in and finding that there are numbers that can be crunched and it shows this, versus this is a document that's been done as part of an assessment of an organization or an entity that represents the membership but maybe that can't be extracted to be true number crunching. And then there's expert opinions and yet another layer of that is that there might be really good data but it only applies to a small subset of the country at the state or maybe regional level. So we're trying to piece this all together with some initial information we can share with you around the first of the year and then this will lead to a formal document.

We are already considering ways to fill in information for which we don't have data sources, which might mean potentially using an expert panel or a small group of individual experts who can help us get insight into some of these areas. There is a dearth of preparedness information so we're working on ways to increase our fill this gap. Now, I'll shift a little to NEMSIS and then I'll answer questions. I happen to be a co-investigator with NEMSIS and am the writer of the data dictionary and data set for version 3.0 which will be released at the end of this month. So as we went through this outline and identified the needs, we were able to tuck some of that information in NEMSIS. So in the future as this rolls out into EMS agencies and states, we will have information in some of these areas we don't have now. So it's been nice to see these projects progress together. My goal as is yours, is to have some good information to be able to identify areas of need and to target from the standpoint of continuing to improve EMS. Mr. Strickland asked if there were any questions and there were none.

EMS STAKEHOLDER MEETING REPORT, Rick Patrick
The National EMS and 9-1-1 Stakeholders Meeting had been suggested and discussed at NHTSA.. In March 2010 we were able to convene approximately 130 EMS stakeholders, including public safety, public health, fire agencies, law enforcement, emergency management, and 9-1-1 dispatchers, federal partners, and FICEMS members at the National Institutes of Health. . The intent of the meeting was to listen from a Federal perspective. Primarily, we wanted to hear from stakeholders. I need to recognize Andrew Kline who made this all happen with a lot of support from Dave Bryson at NHTSA and a number of other FICEMS members who provided administrative support. The information is currently being distilled to make sure we can make sense of all that. The Federal partners ran the meeting and it was a non-consensus approach meaning, so we made it clear to the group that we were not looking for a vote at the end of the meeting. The information in your executive summary was gleaned through kind of a point system as we tried to rank information to identify the most important issues out of 36 big buckets of information. We included the top nine topics in the executive summary and then built from there because there was so much information.

Dr. Garza from the DHS Office of Health Affairs (who funded this project) welcomed the group. After a quick overview of FICEMS, the stakeholders were divided into four focus groups: administrative; clinical; operational; and data and research.

The groups were lead by EMS facilitators and the role of the Federal partners was to listen, be a sponge, absorb information, distill it and report back which is what brings us here today. The nine top areas pulled out in no priority order are:

1) EMS standardization from nomenclature and training as it applies to everything from providers to critical patient care issues to emergency medical dispatching to emergency medical direction to enhance that from a standard perspective if from the Federal level if it's something we can facilitate;
2) Facilitate collection, access and use of research and evaluation that informs clinical practices.
3) Safety
4) Adequate funding
5) A lead federal agency
6) National performance standards were proposed;
7) Development of a vision for the next generation of EMS;
8) A national responder database, perhaps tied into NEMSIS;
9) A national EMS academy.

The FICEMS Technical Working Group is looking at the minutes to see what other information we can get out of that. But I'm going to ask FICEMS how we can move forward. With your input we would like to make this a feature story on EMS.gov, and make it something that Mr. Dawson can get up and posted relatively soon versus the whole formal approval process for minutes. There is no official report.

Mr. Strickland asked for clarity around the issue of readiness funding. Mr. Patrick replied that "funding" in this context meant preparedness planning and operational issues. The emphasis on funding in EMS comes out of CMS from Medicare reimbursement and things like that which

may encompass direct operational issues daily. Yet EMS has been cut out of preparedness funding for catastrophic event response.

Dr. Bass surmised that some of it also came out of the negotiated rulemaking process of the 1990s and early 2000s, where there had been a lot of discussion about the issue of readiness funding. He said preparedness is a component but another issue is daily standby costs. EMS agencies must have an ambulance standing by that can respond to any emergency.CMS' focus was on ensuring what they were paying for specific services provided to Medicare and Medicaid beneficiaries. However, an EMS system has to be available for all patients, not just Medicare and Medicaid beneficiaries. . Daily stand-by costs is an issue that goes beyond Medicare, because insurance companies in general don't want to pay for stand-by costs. In the past, the struggle was that either as a role of volunteer service or community they would pay for that but increasingly the cost of EMS was shifting towards the patients.

Mr. Strickland asked whether stakeholders had thoughts about a resource structure or is this just kind of a problem that this needs to be addressed. Mr. Patrick said he wasn't at every session, but knows this is an issue for FEMA as well with reimbursement when EMS providers are dispatched under the Stafford Act. From an EMS perspective, when EMS personnel are standing by and not actually engaged in patient transport, the funding doesn't cover their overhead. This is not just a CMS issue. It's an overarching question of what gets reimbursed for the expenses overall.

Dr. Bass observed that there is a belief in many systems that they are not reimbursed by CMS at a level of actual costs. As technology has increased or certain meds are maybe given in certain communities which may be as much as $2000, the way they're reimbursed is one fee. So there are a number of challenges in terms of preparedness and standby issues; one issue is how Medicare reimburses because there is increasingly a view that EMS need to play a bigger role beyond just patient transport.

The readiness comments also suggested that there is no sole source or higher percentage representation of funding available to purchase vehicles or equipment for catastrophic events, preparedness and response.
Mr. Strickland noted that at the Department of Transportation, there is a system of administrative draw downs as part of the grant structure to take care of the overhead/structural issues as states administer grants that DOT provides.

Dr. Boyd made a comment on the lead agency concept. He said he has been pushing for this and that outside the beltway the lead agency concept is really appreciated because it means there is a source from which questions can be answered, there is a constituency for program development and it cuts down on duplication of effort.

CULTURE OF SAFETY REQUEST FOR PROPOSALS, Drew Dawson

Mr. Dawson noted that the importance of safety had already been raised as an issue. The FICEMS' Safety and Health Committee, other Federal agencies, the National EMS Advisory Council have all recommended that FICEMS and NHTSA address safety in seems from both a patient standpoint and from an EMS provider standpoint. In response, we currently have a request for proposal (RFP) that is being advertised to develop a culture of safety with a multi-year agenda.

Mr. Strickland called for any discussion and there was none.

EMERGENCY CARE COORDINATION CENTER (ECCC), Dr. Mike Handrigan
Dr. Handrigan gave a brief history of the ECCC then give an update on current priorities and projects. The ECCC was chartered pursuant to the HSPD 21; one of the chapters said "create a lead office for emergency care.". It was created specifically to partner with NHTSA and FICEMS to facilitate the Federal emergency care enterprise, from EMS providers responding in the field to ED physicians providing medical care. The opportunity for the ECCC to partner with FICEMS is immense. The HSPD stemmed from the 2006 IOM report on the state of emergency care for the country which stated that the emergency care systems need to be a coordinated, accountable and regionalized. EMS systems are very fragmented, with multiple service oriented structures so the initial efforts for the ECCC are around building a partnership with NHTSA and to really take the lead on the challenge from the IOM in terms of a regionalized emergency care systems.

Dr. Handrigan stated that ECCC's first efforts were to examine various definitions of regionalized emergency care systems. We looked at multiple examples, such as STEMI care, stroke care, obstetrics, orthopedics, and trauma which is probably the poster child for a regionalized emergency care system., We are also looking at Kaiser and Veteran's Administration. We examined in detail what does regionalization mean, how it fits with a productive emergency care system and how can we move that concept forward in a unified and meaningful way.

The other challenge that the IOM put forward was a regionalized, "accountable" system. In order to account for an activity, we have to be able to measure it. Therefore, a second charge out of the blocks is to develop a framework and structure for measures. The main message I want to convey here today is the partnership and concept of the enterprise. We're on the verge of an enormous opportunity and creating an agency that can serve as the lead Federal agency. We are not there yet, but as an interagency partnership we're there and we are productive. There are two items on the agenda. First, is the effort to find the right way to measure a regionalized emergency care system and we are engaged with an organization called the National Quality Forum (NQF) that partners with the Federal government to do just this for various aspects of medical care. We have reached out to them in partnership with ASPE to establish a framework for regionalized emergency care measures, which will be a three phase project. This will look at emergency care; identify the kinds of measures we need; and then create a framework. Subsequently, a year from now there will be a call for measures so the community can help populate the framework. That project should be kicking off in mid-July and it will be important to get FICEMS input through the NQF. As you can imagine an emergency care system can't exist without EMS as a backbone to that system.

The second issue is the Institutional Review Boards (IRB). One important mission for the ECCC is to look at the operational aspects of emergency care, but also to look at the underpinnings of emergency care including the basic science and clinical research that help promote and improve systems as well as patient care. One of the biggest challenges in having evidence-based care is developing the evidence. One of the main barriers to evidence-based practice is the informed consent process. For the last 20 years, we've been trying to tackle this concept of informed consent. There are multiple ways to get beyond the barriers and produce good evidence and one

of those is conducting research with a waiver or exception from informed consent. Ten years ago, the FDA had a fairly robust discussion on this and it moved the issue forward in research but it still remains a lynchpin in evidence-based practice so we are working with a number of Federal partners to host a meeting to further the dialogue on how to conduct better research and pull folks together. One of the issues is perhaps developing a central IRB process. If multi-site research is being conducted there needs to be a central process for research review. The cancer community has established a very functional IRB process and we want to examine and perhaps promote it in the emergency care community. We are looking in October/November to have that meeting and look forward to FICEMS input.

Mr. Dawson noted that there will be a request for information by the ECCC and they'd like FICEMS' endorsement of that request in preparation for the workshop and would like our name added to their request for information. A motion was made to endorse the request for information and it passed unanimously.

EVIDENCE-BASED PRACTICE MODEL AND UPDATE ON PILOT PROGRAMS,

Cathy Gotschall

Ms. Gotschall noted that the FICEMS Medical Oversight Committee developed as a result of their national meeting the evidence-based guideline model process. And they recently issued an RFP to fund a pilot test of this process which includes the evaluation of the evidence; development of guidelines; the implementation of the guidelines and evaluation of their efficacy. We released an RFP to do a pilot study of the model process and a competitive award was made to the Children's National Medical Center in partnership with the Maryland Institute for Emergency Medical Services System (MIEMSS). The awardees proposed to develop two guidelines: one looking at pre-hospital pain management and another examining the use of helicopters to evacuate trauma victims from the scene of injury. They will be using grade methodology, which is very rigorous and transparent scientific methodology to evaluate scientific literature and other evidence in non-peer reviewed journals, and are developing recommendations. There is an expert panel of adult and pediatric trauma surgeons, adult and pediatric emergency physicians, a firefighter paramedic, a health economist, methodologists in evidence-based guidelines, a well as a medical librarian, subject matter experts in air medical and pain management and physicians who represent important constituencies to the guideline development process. They have created a list of what they call key questions which are being distributed to you.

However, concerning the question about pain management, they are looking at what validated instruments already exist and will evaluate the instruments that are used to predict the need for or patient response to analgesics and are looking at optimal patient criteria and system characteristics to create an environment for analgesic use. In addition, there will be an examination of transport time with respect to the need for analgesics and specific medications, and routes of administration. They also will be looking at efficacy as well as provider acceptance and contra-indications of medication, routes and criteria for the administration of repeat doses, as well as barriers to pre-hospital use of analgesics for pain management.

For those very general questions they will be developing a PICO question which is a very standardized way of looking at the patient population, specific intervention, a comparison for the intervention, and then patient outcomes, whether there are adverse effects or improved health

outcomes. They also will be developing guidelines for use of HEMS and looking at validated criteria and tools, triage instruments, injury risk stratification instruments, and evidence on the safety of ground versus air with respect to medical adverse events during transport. In that regard, there will be an examination of risks to patients and crew due to crashes and they'll also be looking at risks from under- and over-triage of patients.

Further, there will be a determination of when to obtain online medical direction to inform a decision regarding helicopter transport and perhaps developing guidelines for cost benefit analysis from societal as well as an EMS system perspective. They hope to have a draft recommendation ready by end of August or the beginning of September which will be submitted to the EMS board of MIEMSS. The protocol will be reviewed by MIEMSS whose medical director is Dr. Rick Alcorda, one of the co-investigators on the study. It will be assessed by MIEMSS Protocol Evaluation Committee and if approved, will be implemented in Maryland. They will develop a training program for field providers, they have a six-month pre-implementation rollout, and then the protocol will be implemented. The evaluation will look at both process variables—how many providers participated in the training—as well as patient outcomes. Maryland has a Maryland Ambulance Information System where they can scan run sheets and the information goes into a database for the national study center to help determine whether the protocols are being implemented. That's where we are with the study. We will have some observers from the FICEMS Medical Oversight Committee at the expert panel meeting.

Dr Boyd asked why the awardees chose pre-hospital pain management, whether it's because it's a big problem or one that can help easily improve the efficacy of the process? Ms. Gotschall replied that it was chosen because it's what was targeted in the successful proposal. The RFP gave respondents the choice to pick the topic for which to develop evidence-based guidelines and the award was made to this project. She noted that it was a clever bit of grantsmanship to propose not one, but two, guidelines in their applications. Dr. Bass observed that pre-hospital pain management is indeed an issue and that there have been fits and spurts of progress in the past but it's just been languishing the last few years so it was determined that now is an appropriate time to address it. Dr. Boyd noted that working through a low-level non-controversial question like this is good for process development. Dr. Bass pointed out that pain management is not controversial the helicopter issue is. He also noted that the pain piece likely came from the pediatric side and the helicopter issue arose on the adult side. He added that these two projects are where the rubber meets the road; it's not just an academic process. And the translating of protocols, translate from academic to real world.

Ms. Gotschall added that part of the final report is providing feedback to FICEMS on the model process and how it works. Mr. Dawson noted that testing the process is really what this whole thing is about. The helicopter piece was outlined in the proposal response.

He also said it was important to make a distinction here with the national guidelines that will come out and what will be implemented in Maryland just to make sure there's clarity. The national guidelines are one process. Maryland is looking at testing the system to develop protocols. Maryland is not developing the protocol for helicopters, EMS or pain management.

FICEMS OPERATIONS, David Strickland

Mr. Strickland began this aspect of the meeting with a call to discuss what FICEMS does well and where it might need improvement in terms of how it functions. Back in 2004, we were trying to create an interagency body to coordinate all the various Federal functions with regard to EMS with the ultimate goal being to eliminate confusion and increase efficiency. I've always felt strongly that FICEMS was a model of success in this area, but I think there are always areas we can work on to make it more efficient. He advised that the group be mindful of the president's charge to think about how we, moving forward, deal with the nation's infrastructure and that the approaching reauthorization of the surface transportation bill gives the committee some time as well as a ripe policy opportunity to think about how we can make FICEMS work better. What have we found works well? What things can we address to make us a better, stronger, more nimble interagency committee? Thinking about how we project ourselves and support ourselves to our stakeholders across the country is always a worthwhile discussion, particularly as we think about prepping for our next recommendations to Congress. So with all that as preamble, let's have an honest discussion. There are not always opportunities to revise some things but we have some chances in the House and Senate to influence the process as early as we can so we ensure that we come out of this with what we need.

Dr. Boyd observed that one problem is the inside the beltway/outside the beltway schism. We tend to focus on what our sister agencies need and sometimes things get out of proportion with regard to what the real need is in the country. This is a problem we all face and I think this program in its early stages is really quality and on target and relevant. Still this is a problem we have and we need to keep it in mind. Mr. Dawson's work in the field, his knowledge of real world circumstances ripples through this organization and that is great.

Dr. Bass noted that FICEMS is statutorily enabled under the transportation laws but there is also the HSPD 21 and the ECCC. He raised several questions: how do we address the IOM vision of this emergency care enterprise from a structural standpoint? We're addressing EMS issues well, we've got the ECCC over here getting into regionalization issues but how do we create this enterprise? Is it legislation or agreements? There's a need for true integration. The IOM noted that there is fragmentation among pre-hospital care, hospital care and then still further fragmentation. How do we bring this together?

Mr. Strickland replied that he couldn't speak to the specifics of how the pieces will fit together, but could speak generally about the challenges of any option. Having disparate agencies come together in support of a common goal probably works best when there's a little less democracy. Some individuals who are more accustomed to a more democratic process won't have that and with Federal agencies that's always a challenge.

Mr. Strickland noted that working with Congress early and often is extremely important, but that it is also the most difficult approach to policy making. The more the group can align internal policies, the better the outcomes will be for the EMS community.

Dr. Boyd then noted that there are two functions here: transportation and medical care. On the medical side there are elements that reach over. I think we want to watch out for having redundancy in most places. If we have transportation over here and medical care over here, then it tends to separate the two functions. Both needs have to be represented in both spheres, so

consistency is evident on both sides. To fraction out responsibilities will be a force to pull it apart rather than bring it together.

Mr. Strickland added that Mr. Dawson and others explained why FICEMS as an entity was so needed. There are so many components that are interrelated and you can't say it's simply a transport issue versus a medical issue. There were attempts to do this prior to the FICEMS statutory provision a statute was needed in order to bring various government stakeholders together. We do need to keep in mind that there is a question of redundancy.

Dr. Handrigan stated that he didn't discuss the Council for Emergency Medical Care (CEMC) earlier but that the discussion presented a good opportunity to do so. CEMC, The sister organization to FICEMS for the ECCC, is , an interagency body that brings emergency medicine subject matter experts and policy makers together . Mr. Dawson and I have been considering creating common subcommittees between the CEMC and FICEMS to address opportunities for greater cooperation and specifically opportunities to limit duplication of effort.

Dr. Boyd maintained that the emergency care enterprises and pre-hospital -and in-hospital care; in addition, Dr. Boyd mentioned that FICEMS and the CEMC which includes Federal agencies other than DOT and HHS. As HSPD 21 was conceptualized, FICEMS would deal mostly with interagency work around pre-hospital emergency medical services; the ECCC would deal with in-hospital services and the CEMC would provide broad oversight. Altogether, that would constitute the emergency medical enterprise. I think the piece we all need to work on is what that emergency care enterprise looks like eventually. If we can have joint committees between FICEMS and the CEMC that would be an opportunity for all Federal agencies to coordinate and speak with a more unified voice.

Dr. Hunt said since it's being discussed as an enterprise, joint committees are a great first step but at some point maybe we may want to consider joint meetings.

Dr. Bass noted that the poster child for regionalization was trauma care, but now we've got rapidly exploding systems focused on stroke care or stemi care. If somebody calls 9-1-1 they've accessed the system and are on a continuum of care once they get to the hospital. We make a number of decisions however. We employ the best strategies in the field, find the best way to transport patients to the best facility, then do EMS providers stop in the ED or bypass it? At the state level, what's not being looked at are the commonalities present in various care systems. There are common principles and basic infrastructure that needs to be in place to support all of them. We could start looking at this at the national level and then start to bring that together at state, regional and local systems.

Chief Gaines noted that he has to think about the people that he represents including firefighters, paramedics, EMTs, as well as the EMTIs, operating in a rapidly changing environment that's challenging them today. Chief Gaines said his thoughts go to alternative fuels, specifically. The Departments of Energy and Transportation are grinding out regulations that are going to impact them as well as the citizens they serve. What are the implications of all-electric car or cars with hydrogen tanks? FICEMS should play a role in that. Ultimately, the emergency departments are going to be receiving these patients. For EMS personnel, we should be looking at prevention and education on how to minimize injury and work-related exposures to infectious diseases.

Dr. Yeskey asked what FICEMS does with the information we get or the issues we identify. Where does it go from here? I think the stakeholder meeting is a great idea, part of our charge is to identify needs in the community that need to be addressed at the Federal level. But other questions include what recommendations we make on both the executive and legislative sides to get those needs met? Whether it's more funding, new programs, or the elimination of redundancy, they may need our executive leadership to work together.
Mr. Dawson said one thing we struggle with at the TWG level is how we frame issues. I suggest that we as a TWG look at stakeholders input and perhaps bring back to the December meeting an organizational structure for how we better coordinate work among FICEMS, CEMC and member agencies. We should also think about ways to better present information to the FICEMS board. Maybe we give background, options, or make recommendations so we actually come forward with something. There is uncertainty to what options are available and this enterprise might be difficult, but it will be worthwhile.

EMERGING ISSUES FOR EMS, Dr. Hunt
The Center for Disease Control and Prevention's Division of Injury Response mission is to decrease injuries and their adverse health effects.

I would suggest to you that everyone in this room has a profound interest in saving lives. Toward that end, I want to talk about our initiatives on field triage guidelines for injured patients. Dr. Bass mentioned a critical piece of knowledge we have from the largest CDC-funded study out of the Injury Center on national outcomes on trauma center care. This study showed a 25 percent decrease in mortality if a severely injured patient goes to a level one trauma center compared to a non-trauma center. I don't know of any other number in medicine that represents such a return on investment in terms of cost benefit analysis. Therefore it behooves us to take action. What I interpret from stakeholders, national performance standards, IOM and Federal partners is a charge to pursue rigorous evidence-based standards for EMS and 9-1-1 services and a suggestion to use incentives to help ensure compliance.

I want to report briefly on the progress of the synthesis of a national expert panel on triage guidelines for injured patients published in January 2009 We convened an expert panel and develop guidelines on field triage. The guidelines have been endorsed by 17 national organizations ranging from the American College of Surgeons to the National Ski Patrol, with concurrence from NTSHA. In addition to development, we disseminated and looked at state-level implementation. We've disseminated over 300,000 copies of various materials related to field triage guidelines. Seven states have instituted partial adoption of the 1999 guidelines, nine states have instituted full or partial adoption, 17 states have adopted different guidelines and nine states did not have any data available. This extends beyond the 25 percent number because I think it shows some challenges we have independent of IOM and the stakeholder meeting. Can you take national guidelines that people say they want and make that work? So the driver of an ambulance turns the wheel and goes to the right place to get the right patient so we can achieve that 25 percent decrease in mortality. That's where the rubber meets the road. So that is the progress to date. Please feel free to share feedback and feel free to contact me. 25 percent decrease in mortality; it's the right thing to do. At the last stakeholder meeting there was some take home lessons for all of us, this is not easy to do. Clear message we got is that we've got to get into states and work with states and I wish we had more resources. Many other ideas came forward at

that meeting but I wanted to share this with FICEMS because of the incredible 25 percent number. I think this is an important harbinger as we talk about regionalization.

Other Business or Public Comment - None

Meeting Adjourned